OCD and Beyond: Understanding Obsessive-Compulsive Symptoms Across Diagnoses

SOUTHERN PSYCHIATRIC ASSOCIATION &
ALABAMA PHYSICIANS PSYCHIATRIC ASSOCIATION CONFERENCE
OCTOBER 11-15, 2023 HUNTSVILLE, AL

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OCD Basics

- 2-3% lifetime prevalence
- 1.2% 12-month prevalence
- 1 in 200 children
- 4th most commonly diagnosed psychiatric condition
- Runs in families
- Slight female predominance
- Typically earlier onset for males
- The gold standard of OCD is treatment is cognitive behavioral therapy (CBT) with an emphasis on exposure and response prevention (ERP)
- Pharmacotherapy protocol begins with high dose SSRI's

Diagnosis

- **DSM-5 (APA, 2013) Diagnostic Criteria for Obsessive-Compulsive Disorder (300.3)**

A. Presence of obsessions, compulsions, or both:

Obsessions are defined by (1) and (2):

1. Recurrent and persistent ***thoughts, urges, or images*** that are experienced, at some time during the disturbance, as ***intrusive and unwanted***, and that in most individuals cause marked anxiety or distress.

2.The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

Common obsessions

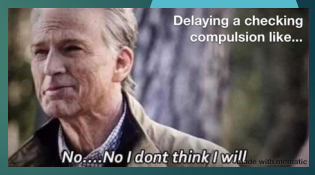
- Contamination
- Aggressive (Harm)
- Sexual
- Symmetry/Just-Right
- Religious/Moral scrupulosity
- Hyper-responsibility/checking
- Sensorimotor/somatic
- Relationship-themed
- Miscellaneous (existential, superstitious, etc.)

Diagnosis

- Compulsions are defined by (1) and (2):
- 1. ***Repetitive behaviors*** (e.g., hand washing, ordering, checking) ***or mental acts*** (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
- 2.The behaviors or mental acts are ***aimed at preventing or reducing anxiety or distress***, or preventing some dreaded event or situation; however, these behaviors or mental acts are **not connected in a realistic way** with what they are designed to neutralize or prevent, or are clearly excessive.
- **B. time consuming, distressing, impairing**
- ***C. not attributable to effects of a substance or medical condition***
- **D. *not better explained by another disorder***

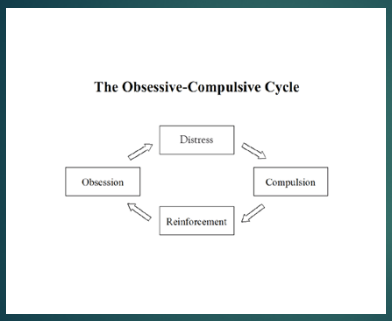
Compulsions

Physical/Overt	Mental/Covert
•Washing, cleaning, grooming •Checking •Repeating •Arranging, ordering, evening •Reassurance-seeking and confessing with others •Avoiding •Miscellaneous ritualistic behaviors	•Rumination, mental review, mental checking •Memory hoarding •Self-criticism and self-punishment •Thought neutralizing •Compulsive prayer •Self-reassurance and rationalizing •Counting and mental chanting compulsions



Essential treatment concepts

- Cognitive Behavioral Therapy
  - Cognitive restructuring
  - Exposure and Response Prevention (ERP)
  - ACT, DBT, and other variations
  - Mindfulness skills development
- ERP = Learning Theories
  - Habituation
  - Inhibitory Learning



The O-C Cycle

Disorders that look like OCD and are often treated similarly

- Generalized Anxiety Disorder
  - Unwanted intrusive thoughts tend to be about on-the-ground concerns, such as health, work, finances, relationships, general safety
  - Primary compulsive behaviors tend to be worry/rumination, avoidance, and reassurance-seeking
  - Tends to take on OCD-like properties with higher severity
- Social Phobia/Social Anxiety Disorder
  - Unwanted thoughts focused on negative evaluation from others
  - Compulsions tend to include social avoidance, rumination about evaluation, reassurance-seeking about social behavior

Disorders that look like OCD and are often treated similarly

- Specific Phobias
  - Unwanted thoughts focused on a singular trigger or experience (e.g. snakes, vomiting, etc.)
  - Compulsions generally involve avoidance, checking, reassurance-seeking
- Body Dysmorphic Disorder
  - Unwanted thoughts about physical appearance
  - Checking, ruminating, reassurance-seeking, camouflaging, social avoidance, surgery

Disorders that look like OCD and are often treated similarly

- Illness Anxiety Disorder/Health anxiety (also Somatic Symptom Disorder)
  - Unwanted thoughts about having or getting an illness
  - Reassurance-seeking, researching, checking, ruminating
- Panic Disorder with Agoraphobia
  - Presence of and fear of having panic attacks
  - Avoidance, reassurance, symptom checking, safety behaviors

Disorders that *can* look like OCD and are *not* (but may co-occur!)

- Mood disorders
  - Obsessions and compulsions may be present only during hypomania/mania
  - Mixed state bipolar manifesting as agitated depression – 24/7 non-targeted anxiety/dread with rumination
  - Depressive rumination (incl. w/ psychotic features)
- OCPD
  - Ego syntonic perfectionism and rigidity
  - Most common co-occurring PD
- Avoidant, dependent, narcissistic and other PD's
  - May include avoidance, reassurance-seeking, perfectionism/rigidity/over-control behaviors

Disorders that *can* look like OCD and are *not* (but may co-occur!)

- Borderline personality disorder
  - May include obsessive fears of abandonment and reassurance-seeking
  - Often includes moral obsessions, harm obsessions, and sexual obsessions fueled by instability of self concept
- Impulse control disorders
  - So-called "compulsive" gambling, shopping, eating, etc.
- Substance Use Disorders
  - May include rituals around use and may be used as self-medication or avoidance
- Schizoaffective disorders
  - Rituals driven by auditory hallucinations, other psychotic symptoms, etc.

Disorders that can look like OCD and are not (but may co-occur!)

- Eating disorders
  - Rigidity, rituals, and food avoidance all with core intention to change weight
  - Orthorexia and some ARFID subtypes may be more similar to OCD
- Misophonia
  - Anger, agitation, avoidance of triggering sounds
- Autism spectrum disorders/pervasive developmental disorders
  - May include concrete thinking, rigidity, avoidance, repetitive behaviors, and rituals, as well as socially phobic symptoms

Disorders that can look like OCD and are not (but may co-occur!)

- Attention deficit disorders
  - May include behaviors that appear ritualistic, perfectionistic, over-controlled or avoidant but aimed at organizing/prioritizing or coping with rapid thoughts
- Post traumatic stress disorders
  - May include ritualistic or impractical efforts to avoid retraumatization
  - Avoidance, checking, safety behaviors may share territory with ritualistic behavior

Lessons from a residential program

- Male, 20s, referred by outpatient OCD specialist
  - Moderate childhood history of anxiety, obsessive tendencies, perfectionism
  - Traumatic loss of both parents and abandonment by foster parents
  - Sought outpatient therapy initially for unwanted intrusive thoughts of having harmed someone
  - Compulsive rumination, reassurance-seeking
  - Obsessive doubt was resolved when he actually re-encountered the person he thought he harmed, but rumination did not cease
  - 24/7 anxiety, difficulty sleeping, obsessive concern with never getting better, irritability, suicidal ideation

Lessons from a residential program

- Female, 30s, lifelong history of OCD
  - Longstanding issue of engaging in long and ritualistic hygiene/shower routines with the expressed purpose of making sure nothing catastrophic will occur the following day
  - Expresses concern that she lacks empathy, wants to know if she has a personality disorder
  - Describes her morality as a function of parental modeling
  - Decided to get treatment after an episode of overwhelm at work

Lessons from a residential program

- Male, 30s, sudden onset
  - No history of OCD prior to the birth of his child several months ago. Has unwanted intrusive thoughts of sexually abusing the baby. Does not like the thoughts.
  - Symptoms of social anxiety, concern that others are evaluating him negatively.
  - Reports feelings of guilt and shame that he had cheated on his wife years ago, but no evidence this occurred, and she did not believe him
  - Tries to talk back to his intrusive thoughts. Is afraid to be around the baby.

Lessons from a residential program

- Female, late 20s, childhood onset, but content shift
  - Childhood rituals, fear of getting sick
  - More recent presentation of intrusive thoughts of a taboo, harm, and sexual nature
  - Severe moral scrupulosity, focus on concept of being a "bad" person
  - Chronic suicidality with a recent attempt by overdose
  - Significant history of sexual trauma and multiple deaths in the family
  - "Doorknobbing" behavior, between-session pleas for support, tendency to accuse provider of withholding negative evaluations, splitting between providers
  - Self-described expert in OCD, read all the books, watched all the webinars

Questions to consider

- Are the "obsessions" ego dystonic?
- Are the compulsions impairing? Time consuming? Is the patient *compelled* to engage in these behaviors?
- Do the O-C symptoms occur in episodes and do these episodes track with other symptoms/behaviors?
- Where is the patient's locus of control? Do they view themselves as the problem or the world?
- What is the specific function of the seemingly compulsive behavior? Certainty, safety, control, sensory-seeking, emotion regulation, avoidance?

Takeaways

- Many psychiatric conditions involve obsessions (or symptoms that appear that way) and compulsions (or symptoms that appear that way)
- "Obsessing" means "engaging in mental behavior" and is distinct from simply being presented with unwanted thoughts/images/urges
- Patients organized around an OCD diagnosis may be resistant to alternative or additional diagnoses due to
  - History of providers failing to diagnose OCD correctly
  - Stigma around mental health in society (e.g. "isn't everyone a little OCD?")
  - OCD conceptualization and effective treatment O-C symptoms have reduced suffering, but relapses persist due to other conditions or patient remains significantly impaired
- Team-based, collaborative approach across disciplines is the key to diagnostic clarification and effective treatment

Thank You!

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